

VOCATIONAL REHABILITATION and the Supplemental Job Displacement Benefit:

Returning an Injured State Employee to Work



State Compensation Insurance Fund

Vocational rehabilitation services are provided to an injured employee who is unable to return to work in his or her date of injury occupation. The State of California, the employer, and the State Compensation Insurance Fund (SCIF) need to work together in order to return an injured employee to a productive and useful place in the community, with a priority on returning him or her to employment with the State.

Vocational Rehabilitation Services are provided to injured employees, with dates of injury on or before December 31, 2003, who cannot return to their usual and customary position, even with modifications, vocational rehabilitation benefits are available. These services are outlined in the 2003 edition of the California Labor Code (LC) in Section 4635 (d), which states:

- Services required to determine if an employee can reasonably be expected to return to suitable gainful employment;
- Services reasonably necessary to provide an employee with the opportunity to return to suitable gainful employment; and
- These services may include, but are not limited to, vocational and medical evaluation, counseling, job analysis, job modification assistance, retraining, including on-the-job training or training for alternative employment, formal training, academic instruction, and job placement assistance

When vocational rehabilitation services are needed one of the primary goals is to provide the injured employee with an opportunity to return to suitable gainful employment. LC Section 4635 (f) defines suitable gainful employment as follows:

- Employment or self-employment which is reasonably attainable and which offers an opportunity to restore the employee as soon as practicable and as near as possible to maximum self-support, due consideration being given to the employee's qualifications, likely permanent disability, vocational interests and aptitudes, pre-injury earnings and future earning capacity, and the present and projected labor market. No one factor shall be considered solely in determining suitable gainful employment.

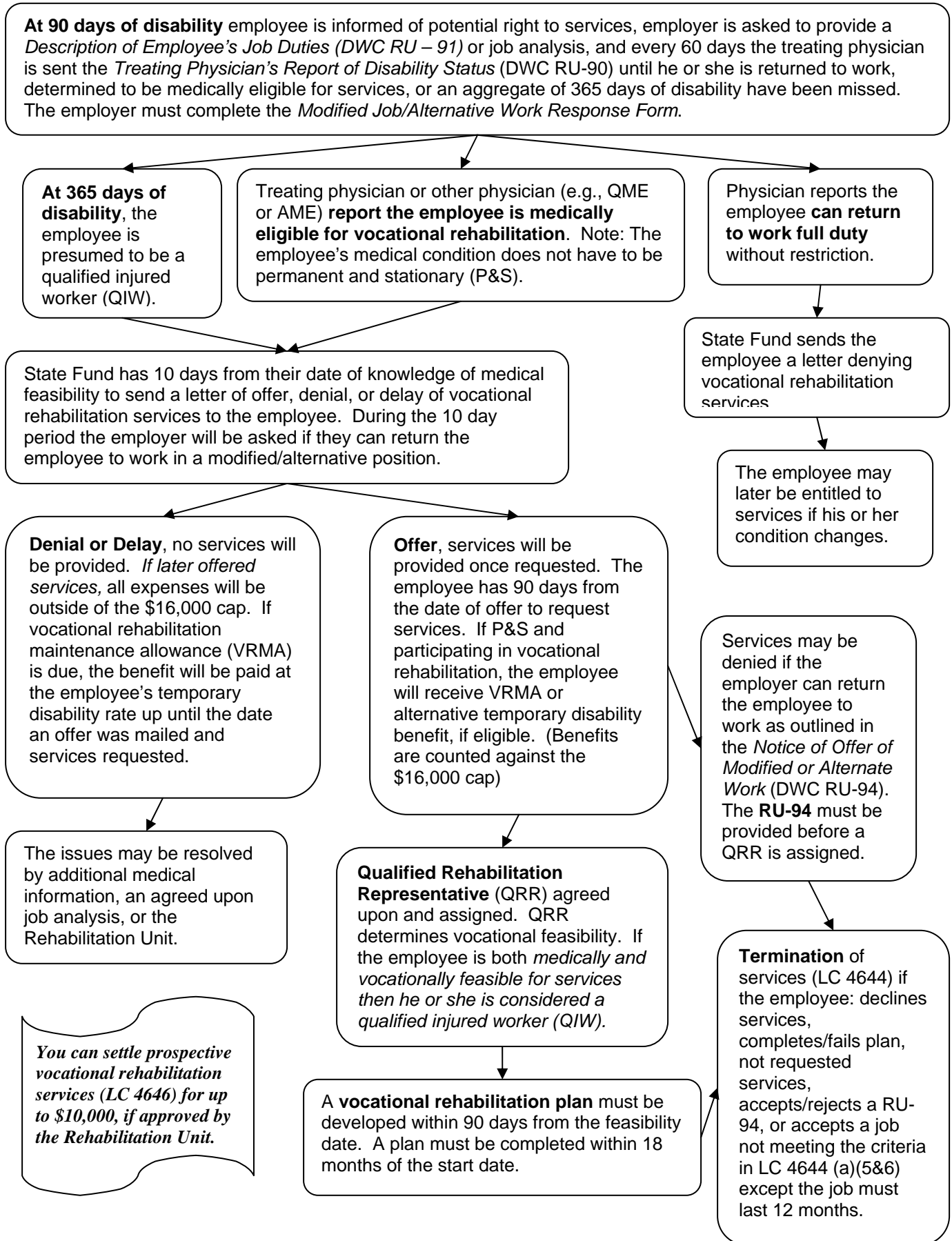
In general, vocational rehabilitation is handled in the same manner for both public and private sector employees. The State may provide a vocational rehabilitation plan to any employee who becomes disabled on an industrial basis and needs a permanent work change. The aggregate cost of vocational skill training offered through the plan is limited to a maximum of \$16,000. Generally, an injured worker is paid Vocational Rehabilitation Maintenance Allowance (VRMA), which is less than Temporary Disability (TD) payments but greater than the employee would receive from Permanent Disability (PD) payments. It is critical to understand the overall structure of State civil service and how the benefits of State service impact the management of the vocational rehabilitation services available to an injured State employee.

Vocation rehabilitation services were repealed (LC Sections 135.5, 4635-4347, & 5405.5) effective January 1, 2004 and replaced with the Supplemental Job Displacement Benefit (SJDB). The SJDB is provided to an eligible injured employee with a date of injury occurring on or after January 1, 2004. The SJDB is a voucher for a retraining or skill enhancement program at a state approved or accredited school. The voucher can range in value up to \$10,000 based on the level of an injured employee's permanent disability and can be used towards tuition, fees, books, vocational rehabilitation counselor services, and other related expenses. There is no longer a provision for VRMA.

To be eligible an injured employee must not have been returned to work with his or her employer within 60 days after his or her temporary disability period and has a permanent disability. However the employer is not liable for the SJDB if they offer the injured employee modified or alternative work within 30 days of his or her temporary disability period. The modified or alternative work must pay at least 85% of the date of injury salary, last at least 12 months, be within a reasonable commuting distance, and accommodate the work restrictions.

The following section provides an overview of the vocational rehabilitations services available to an injured employee who is unable to return to his or her usual and customary occupation, the vocational rehabilitation process, your responsibilities, and information on the SJDB.

VOCATIONAL REHABILITATION PROCESS



Qualified Injured Worker

- LC 4635 (a) (1) Medical Eligibility: An employee's expected permanent disability as a result of the injury, whether or not combined with the effects of a prior injury or disability, if any, permanently precludes, or is likely to preclude, the employee from engaging in his or her usual occupation or the position in which he or she was engaged at the time of injury.
- LC 4635 (a) (2) Vocational Feasibility: The employee can reasonably be expected to return to suitable gainful employment through the provision of vocational rehabilitation services.

Qualified Injured Workers (QIW) Identification Process

LC 4636

- When aggregate total disability continues for 90 days, the employer shall provide to the employee information on the Americans with Disabilities Act, Fair Employment and Housing Act, and the nature and scope of vocational rehabilitation services.
- If the employee has not previously been identified as being medically eligible for vocational services, the employer shall provide a jointly developed job description with the physical requirements of the employee's duties to the treating physician.
- Continue to follow-up with the treating physician at least every 60 days until:
 - Employee is released to return to his/her usual occupation
 - Employee is determined to be medically eligible for vocational rehabilitation
 - When aggregate total disability exceeds 365 days, the employee is presumed to be QIW.

NOTE: AN EMPLOYEE'S MEDICAL STATUS DOES NOT NEED TO BE PERMANENT AND STATIONARY BEFORE DETERMINING MEDICAL ELIGIBILITY FOR SERVICES.

Permanent and Stationary (P&S)

- Employee does not have to be P&S to participate in vocational rehabilitation.
- If an employee's work restrictions are not known, a functional capacity evaluation or work evaluation may provide useful information.
- Employee's weekly disability rate will likely drop once they become P&S – and the \$16,000 cap starts.
- The longer an employee is off work, the harder it is to return to work successfully.

Description of Employee's Job Duties

- If possible, have an agreed-upon job description/job analysis on file and submit it to SCIF with the Employer's Report of Occupational Injury or Illness form (SCIF 3067). The job description must describe the physical requirements of the job.
- SCIF will mail you the Description of Employee's Job Duties form (DWC RU-91), if one is not available and the injured worker is temporarily disabled for 45 days or more.
- Complete and return the RU-91 to SCIF as soon as possible.

Job Analysis

- It is crucial that a job description contains all of the information the physician needs to determine if an employee is medically eligible for vocational services.
- A job analysis can detail the specific duties of a job or the psychological stresses that are difficult to describe in a job description.
- If an employer and employee cannot agree on the job description, then a job analysis can be requested.
- The usual fee for a job analysis is \$325, plus mileage, but may be higher.

Description of Employee's Job Duties (DWC Form RU-91) - Front

State of California
Division of Workers' Compensation

DESCRIPTION OF EMPLOYEE'S JOB DUTIES

INSTRUCTIONS: This form shall be developed jointly by the employer and employee and is intended to describe the employee's job duties. The completed form will be reviewed by the treating doctor to determine whether the employee is able to return to his/her job. This is an important document and should accurately show the requirements of the employee's job. If the employee needs help in completing this form, the employee may contact the Information and Assistance Officer at the Division of Workers' Compensation. The phone number can be found in the State Government section of the phone book.

EMPLOYEE NAME:	(LAST)	(FIRST)	(M.I.)	CLAIM #:
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EMPLOYER NAME:	JOB ADDRESS:
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JOB TITLE:	HRS. WORKED PER DAY:	HRS. WORKED PER WEEK:
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DESCRIPTION OF JOB RESPONSIBILITIES: (DESCRIBE ALL JOB DUTIES)

1. Check the frequency of activity required of the employee to perform the job.

ACTIVITY (Hours per day)	NEVER 0 hours	OCCASIONALLY up to 3 hours	FREQUENTLY 3-6 hours	CONSTANTLY 6-8+ hours
Sitting				
Walking				
Standing				
Bending (neck)				
Bending (waist)				
Squatting				
Climbing				
Kneeling				
Crawling				
Twisting (neck)				
Twisting (waist)				
Hand Use: Dominant hand Right ___ Left ___				
Is repetitive use of hand required?				
Simple Grasping (right hand)				
Simple Grasping (left hand)				
Power Grasping (right hand)				
Power Grasping (left hand)				
Fine Manipulation (right hand)				
Fine Manipulation (left hand)				
Pushing & Pulling (right hand)				
Pushing & Pulling (left hand)				
Reaching (above shoulder level)				
Reaching (below shoulder level)				

DWC Form RU-91 (1/95)

Description of Employee's Job Duties (DWC Form RU-91) – Back

2. Please indicate the daily Lifting and Carrying requirements of the job:
Indicate the height the object is lifted from floor, table or overhead location and the distance the object is carried.

	LIFTING					CARRYING				
	Never 0 hours	Occasionally up to 3 hours	Frequently 3–6 hours	Constantly 6–8+ hours	Height	Never 0 hours	Occasionally up to 3 hours	Frequently 3–6 hours	Constantly 6–8+ hours	Distance
0–10 lbs.										
11–25 lbs.										
26–50 lbs.										
51–75 lbs.										
76–100 lbs.										
100+ lbs.										

Describe the heaviest item required to carry and the distance to be carried: _____

3. Please indicate if your job requires:

	YES	NO	(IF YES, PLEASE BRIEFLY DESCRIBE)
a. Driving cars, trucks, forklifts and other equipment?	<input type="checkbox"/>	<input type="checkbox"/>	_____
b. Working around equipment and machinery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
c. Walking on uneven ground?	<input type="checkbox"/>	<input type="checkbox"/>	_____
d. Exposure to excessive noise?	<input type="checkbox"/>	<input type="checkbox"/>	_____
e. Exposure to extremes in temperature, humidity or wetness?	<input type="checkbox"/>	<input type="checkbox"/>	_____
f. Exposure to dust, gas, fumes, or chemicals?	<input type="checkbox"/>	<input type="checkbox"/>	_____
g. Working at heights?	<input type="checkbox"/>	<input type="checkbox"/>	_____
h. Operation of foot controls or repetitive foot movement?	<input type="checkbox"/>	<input type="checkbox"/>	_____
i. Use of special visual or auditory protective equipment?	<input type="checkbox"/>	<input type="checkbox"/>	_____
j. Working with bio-hazards such as: bloodborne pathogens, sewage, hospital waste, etc.	<input type="checkbox"/>	<input type="checkbox"/>	_____

Employee Comments:

Employer Comments:

EMPLOYER CONTACT NAME:	EMPLOYER CONTACT TITLE:
EMPLOYER REPRESENTATIVE SIGNATURE:	DATE:
EMPLOYEE'S SIGNATURE:	DATE:
QUALIFIED REHAB. REPRESENTATIVE SIGNATURE: (IF APPLICABLE)	DATE:

DWC Form RU-91 (1/95)

Treating Physician's Report of Disability Status (DWC Form RU-90)

TREATING PHYSICIAN'S REPORT OF DISABILITY STATUS

INSTRUCTIONS: Pursuant to requirements of the California Labor Code, please complete this form and return it to the claims administrator listed below within 15 days of receipt with a copy to the Qualified Rehabilitation Representative.

EMPLOYEE NAME:	(LAST)	(FIRST)	(M.I.)	SS#	DATE OF INJURY
EMPLOYER NAME:					
<p>Attached is a description of the employee's job duties. Based on your examination, including the history provided by the patient and the enclosed job description, choose one of the following:</p> <p>_____ I expect to release the employee to return to the pre-injury occupation on or about _____.</p> <p>_____ The employee's permanent disability as a result of the injury whether or not combined with the effects of a prior injury or disability, if any is likely to preclude the employee from returning to work at the pre-injury occupation.</p> <p>Is the employee currently physically able to participate in vocational rehabilitation services? _____ Yes _____ No</p> <p>If yes, please describe any physical limitations: _____</p> <p>_____</p> <p>If employee is not physically able to participate in vocational services, please estimate when participation may be possible.</p> <p>_____</p> <p>_____ At this time, I am unable to give an opinion concerning the employee's ability to return to the pre-injury occupation.</p> <p>I expect to be able to provide an opinion on or about: _____</p>					
<p>Please advise also if the employee is currently physically able to perform light duties if modified or alternative work is available:</p> <p>_____ Yes, with the following limitations: _____</p> <p>_____ No</p>					
Physician's Name: _____			Date: _____		
Physician's Signature: _____					
Please return to: Employer/Insurer/Adjusting Agent					
<p>Address: _____</p> <p style="text-align: center;">(Street) (City) (State) (Zip)</p>					
Send a copy to Qualified Rehabilitation Representative:					
<p>Address: _____</p> <p style="text-align: center;">(Street) (City) (State) (Zip)</p>					

State of California
DWC Form RU-90 (12/90)

Qualified Injured Worker Notification

- Notice of Potential Eligibility (NOPE) Types: Offer, Denial, Delay must be sent to the employee within 10 days of knowledge that the injured employee is medically eligible for services.
- During the 10 day period the employer is asked if they can return the injured employee to modified or alternative work.
- If so, the employer needs to provide the employee with an Offer of Modified/Alternative Work form (DWC RU-94).
- If not, the \$16,000 vocational rehabilitation cap won't begin until:
- -NOPE Offer Letter is sent to injured worker.
- -Injured worker receives notice that there is no modified or alternative work available.
- -Employee requests services
- If a NOPE Denial or NOPE Delay Letter is sent then no services will be provided until the issues are resolved. If vocational services are later provided then all cost up to the date of offer and employee's request are outside of the cap.

Notice of Offer of Modified or Alternate Work (DWC RU-94)

- Employee must have the ability to perform the essential functions of the job.
- The job is a regular position lasting at least 12 months.
- The job offers wages and compensation within 15% of those paid at time of injury.
- The job is located within reasonable commuting distance of employee's residence at the time of injury.
- Employee has 30 calendar days to accept or reject job offer.
- Liability for vocational rehabilitation services terminates if above conditions are met.

RU-94 Suggestions

- Explore modified/alternate work possibilities as early as possible - provide temporary light-duty work if possible while employee is still Temporary Disabled.
- Provide employee with RU-94 form as soon as a permanent modified or alternate job is offered.
- Attach a list of job duties – the job does not have to be approved by the treating physician first.
- Liability for voc rehab is terminated even if employee rejects the job offer as long as required conditions are met.

Notice of Offer of Modified or Alternative Work (DWC Form RU-94)

NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK

THIS SECTION COMPLETED BY EMPLOYER OR CLAIMS ADMINISTRATOR:

Employer (name of firm) _____ is offering you the position of a
(name of job) _____.

Attach a list of the duties required of the position.

You may contact _____ concerning this offer. Phone No.: _____

Date of offer: _____ Date job starts: _____

Claims Administrator: _____ Claim Number: _____

NOTICE TO EMPLOYEE Name of employee: _____

Date offer received: _____

You have 30 calendar days from receipt to accept or reject this offer of modified or alternative work. If you reject this job offer, you will not be entitled to rehabilitation services unless:

Modified Work

- A. The proposed modification(s) to accommodate required work restrictions are inadequate.
- B. The modified job will not last 12 months.

Alternative Work

- A. You cannot perform the essential functions of the job; or
- B. The job is not a regular position lasting at least 12 months; or
- C. Wages and compensation offered were less than 85% paid at the time of injury; or
- D. The job is beyond a reasonable commuting distance from residence at time of injury.

THIS SECTION TO BE COMPLETED BY EMPLOYEE

___ I accept this offer of Modified or Alternative work.

___ I reject this offer of Modified or Alternative work and understand that I am not entitled to vocational rehabilitation services.

Signature

Date _____

I feel I cannot accept this offer because:

NOTICE TO THE PARTIES

If the offer is not accepted or rejected within 30 days of the offer, the offer is deemed to be rejected by the employee.

The employer or claims administrator must forward a completed copy of this agreement to the Rehabilitation Unit with a Notice of Termination (DWC Form RU-105) within 30 days of acceptance or rejection.

If a dispute occurs regarding the above offer or agreement, either party may request the Rehabilitation Unit to resolve the dispute by filing a Request for Dispute Resolution (DWC Form RU-103) at the applicable Rehabilitation Unit. The Rehabilitation Unit venue is the same as the Workers' Compensation Appeals Board. If no WCAB case exists, file with a Rehabilitation Unit at the appropriate district office.

MANDATORY FORMAT
STATE OF CALIFORNIA
DWC-RU-94 (01/03) §10133.12

Vocational Feasibility

- Is the employee reasonably expected to return to suitable gainful employment?
- The Qualified Rehabilitation Representative (QRR), who is an outside vocational counselor, determines feasibility
- A vocational rehabilitation plan must be developed within 90 days of the feasibility date.
- If employee is not feasible, he or she is not a qualified injured worker, and no further benefits are due.
- If not feasible, it is possible that the employee's is a 100% disabled. A dispute may arise over whether or not the employee has a 100% permanent disability???
- The employee may later become feasible and at that time he or she may be eligible for services.

Vocational Rehabilitation Plans

- The rationale for the manner and means by which it is proposed that a qualified injured worker may be returned to suitable gainful employment
- Post 1/1/94 dates of injury
 - plans for unrepresented injured workers must be approved by the Rehabilitation Unit
 - \$16,000 cap on all voc rehab expenses
 - 52 week limit on VRMA
 - 18 month limit to from plan commencement
- Types of plans:
 - Modified Job/Alternate Work
 - Direct Placement
 - On-the-job Training
 - Educational Retraining
 - Self-employment

Vocational Rehabilitation Plan (DWC Form RU-102) – page 1 of 4

VOCATIONAL REHABILITATION PLAN		REHABILITATION USE ONLY	
Social Security Number		WCAB Number	Rehab Unit Number
Employee Name (Last)	(First)	(MI)	Date of Birth
Address (Street)	(City)	(State)	(Zip)
Employer Name		Insurance Company Name; Or, if Self-Insured, Certificate Name	
Address		Adjusting Agency Name (if adjusted)	
City, State, Zip		Claims Mailing Address	
Date of Injury	Claim Number	City, State, Zip	Phone No.
Employee Representative		Employer Representative	
Firm Name		Firm Name	
Address		Address	
City, State, Zip	Phone No.	City, State, Zip	Phone No.
Qualified Rehabilitation Representative			
Firm Name Representative Name			
Address (Street, City, State, Zip)			Phone No.

SECTION A

OCCUPATION AT INJURY	EARNINGS AT INJURY
DESCRIBE TYPE OF INJURY AND MEDICAL RESTRICTIONS (both industrial and non-industrial. Also identify medical report relied upon):	
SUMMARY OF EMPLOYEE'S EDUCATIONAL AND VOCATIONAL BACKGROUND AND EXPLANATION OF HOW TRANSFERRABLE SKILLS HAVE BEEN USED IN SELECTION OF THE PLAN OBJECTIVE:	
REHAB UNIT APPROVAL IS REQUIRED DUE TO: Check one: <input type="checkbox"/> Unrepresented Injured Worker <input type="checkbox"/> QRR Waiver <input type="checkbox"/> Pre '94 Dates of Injury <input type="checkbox"/> Discretionary Monies	
Initials	

(Voc. Rehab.) §10133.13

Mandatory Format
State of California
DWC Form RU-102 (1/03)

Vocational Rehabilitation Plan (DWC Form RU-102) – page 2 of 4

SECTION B	
VOCATIONAL OBJECTIVE	ESTIMATED WEEKLY EARNINGS UPON COMPLETION
Type of Plan	
<p>With Same Employer</p> <p><input type="checkbox"/> 1. Modified Job</p> <p><input type="checkbox"/> 2. Alternative Work</p>	<p>With New Employer</p> <p><input type="checkbox"/> 3. Direct Placement</p> <p><input type="checkbox"/> 4. On-The-Job Training</p> <p><input type="checkbox"/> 5. Educational Training</p> <p><input type="checkbox"/> 6. Self-Employment</p>
<p>DESCRIBE NATURE AND EXTENT OF REHABILITATION PLAN:</p>	
<p>DATE VOCATIONAL FEASIBILITY DETERMINED: _____</p> <p>PLAN COMMENCEMENT DATE: _____</p> <p>EXPECTED COMPLETION DATE (Including placement assistance): _____</p> <p>#WEEKS OF TRAINING _____ #DAYS OF PLACEMENT ASSISTANCE _____</p>	
<p style="text-align: center;">INITIALS</p>	

(Voc. Rehab.) §10133.13

Mandatory Format
State of California
DWC Form RU-102 (1/03)

Vocational Rehabilitation Plan (DWC Form RU-102) – page 3 of 4

BUDGET FOR VOCATIONAL REHABILITATION PLAN EXPENDITURES

Identify incurred and estimated costs for this rehabilitation plan. For injuries on or after 1/1/94, the maximum expenditure for vocational rehabilitation expenses shall not exceed \$16,000.

RESOURCES TO EMPLOYEE

\$ _____ Weekly VRMA Rate	\$ _____ withheld for attorney fees;	\$ _____ Payment to employee
VRMA/VRTD paid prior to plan (including attorney fees)		Total: \$ _____
Dates: From _____ to _____		
VRMA/VRTD to be paid during plan (including attorney fees)		Total: \$ _____
Dates: From _____ to _____		
Transportation Expenses to be paid as follows: \$ _____ per _____		Total: \$ _____

PLAN EXPENDITURES

Training/Tuition fees, if any (specify recipient): \$ _____		Total: \$ _____
Other Costs (specific type, recipient and method of payment)		
_____	\$ _____ / _____	Total: \$ _____
_____	\$ _____ / _____	Total: \$ _____
_____	\$ _____ / _____	Total: \$ _____
_____	\$ _____ / _____	Total: \$ _____

FEES FOR EVALUATION, PLAN DEVELOPMENT & PLACEMENT

(List Evaluation and Plan Development fees to date and estimated fees for Plan Monitoring and Placement)			
Phase I:	Evaluation	\$ _____	DOIs on /after 1/1/94 where VR was initiated on/after 1/1/98
Phase II	Plan Development	\$ _____	Phase A: \$ _____
	Plan Monitoring	\$ _____	Phase B: \$ _____
Phase III	Placement	\$ _____	Total: \$ _____
TOTAL ESTIMATE OF PLAN EXPENDITURES:			\$ _____

ADDITIONAL RESOURCES TO EMPLOYEE

Permanent Disability Supplement paid to date: \$ _____ / Week		Total: \$ _____
Permanent Disability Supplement to be paid: \$ _____ / Week		Total: \$ _____
Other resources to be provided to employee (identify source and amount):		
_____	\$ _____ / _____	Total: \$ _____
_____	\$ _____ / _____	Total: \$ _____

SECTION C

1. List results of vocational testing, if any, and how they support the vocational objective:
2. Describe why this employee will be employable in the vocational objective of this plan. Include assessment of labor market.

INITIALS

(Voc. Rehab.) §10133.13

Mandatory Format
State of California
DWC Form RU-102 (1/03)

Vocational Rehabilitation Plan (DWC Form RU-102) – page 4 of 4

SECTION D

RESPONSIBILITIES OF THE CLAIMS ADMINISTRATOR:

The claims administrator shall provide in a timely manner all vocational services and benefits necessitated by the agreed upon vocational rehabilitation plan and as required by the Labor Code. I verify that the insurer does not have a proprietary interest in the rehabilitation provider or facilities used in the development or implementation of this plan.

Other:

Signature

RESPONSIBILITIES OF THE EMPLOYEE:

The employee shall be available and reasonably cooperate in the provision of vocational rehabilitation services. The employee shall arrive on time and participate in all scheduled activities; if for any reason the employee does not, he or she must immediately provide an explanation to the Qualified Rehabilitation Representative.

The employee shall follow the requirements of all facilities and persons providing vocational rehabilitation services. The employee shall notify the Qualified Rehabilitation Representative about anything that may interfere with scheduled completion of this plan.

Other

SECTION E

VERIFICATION OF THE QUALIFIED REHABILITATION REPRESENTATIVE

1. This plan was developed by me as the Qualified Rehabilitation Representative or as an Independent Vocational Evaluator. It is my opinion that the services contained in this plan will provide the employee with the opportunity to return to suitable gainful employment.
2. The employee was not referred for services for evaluation, education or training to a facility in which I, my spouse, my employer or co-employee has a proprietary interest or which I, my spouse, my employer or co-employee has a contractual relationship.

Signature

Date

Firm Name & Address

SECTION F

PLAN AGREEMENT

Signature of the claims administrator and employee on this plan shall be deemed to be an agreement that claims administrator and employee intend to comply with all the plan's provisions.

Failure of the claims administrator to provide in a timely manner all services required by the plan may result in the employee being entitled to additional services.

Failure of the employee to comply with the provisions and schedules developed for this plan may result in termination of the employer's liability for rehabilitation services.

I have read and understand all four pages of this plan and agree with all of the plan's provisions.

NAME OF EMPLOYEE

SIGNATURE

DATE

NAME OF EMPLOYEE REPRESENTATIVE (if any):

SIGNATURE

DATE

PERSON AUTHORIZING THE PROVISION OF THIS PLAN ON BEHALF OF THE EMPLOYER/CLAIMS ADMINISTRATOR
NAME

SIGNATURE

DATE

PERSONS SIGNING THIS SECTION SHALL ALSO INITIAL THE OTHER THREE PAGES IN THE INITIAL BOX

(Voc. Rehab.) §10133.13

Mandatory Format
State of California
DWC Form RU-102 (1/03)

Termination of Liability

- LC 4644 The liability of the employer for vocational rehabilitation services shall terminate when any of the following events occur:
 - The employee declines and signs RU-107 form.
 - The employee completes a rehabilitation plan.
 - The employee unreasonably fails to complete a vocational rehabilitation plan.
 - The employee has not requested vocational rehabilitation within 90 days of offer The employer offers and the employee accepts/rejects modified work lasting 12 months, even if the employee voluntarily quits prior to the end of the 12 month period
 - The employer offers and the employee accept/rejects alternate work meeting all the conditions listed in Labor Code 4644 (a)(6).
 - The employer offers and the employee accepts job not meeting criteria listed above.

Notice of Termination of Vocational Rehabilitation Benefits (DWC Form RU-105) Front – Dates of Injury On or After 1/1/90

NOTICE OF TERMINATION OF VOCATIONAL REHABILITATION SERVICES		Rehabilitation Use Only	
Social Security Number		WCAB Number	
Rehab Unit Number			
Employee Name (Last)	(First)	(MI)	Date of Birth
Address (Street)		(City)	(State) (Zip)
Employer Name		Insurance Company Name; Or, if Self-Insured, Certificate Name	
Address		Adjusting Agency Name (if adjusted)	
City, State, Zip		Claims Mailing Address	
Date of Injury	Claim Number	City, State, Zip	Phone No.
Employee Representative		Employer Representative	
Firm Name		Firm Name	
Address		Address Phone No.	
City, State, Zip	Phone No.	City, State, Zip	
Qualified Rehabilitation Representative			
Firm Name		Representative Name	
Address (Street, City, State, Zip)		Phone No.	

CLOSURE REASONS (Check one box which applies)

- ☐ 1. The employee declines and has signed the RU-107 or RU-107A.
- ☐ 2. The qualified employee completes a vocational rehabilitation plan.
- ☐ 3. The qualified employee unreasonably fails to complete a vocational rehabilitation plan.
- ☐ 4. The employee has not requested vocational rehabilitation within 90 days.
- ☐ 5. The employer offers and the employee accepts/rejects modified work lasting 12 months, even if the employee voluntarily quits prior to the end of the 12 month period. *(Attach RU-94)*
- ☐ 6. The employer offers and the employee accepts/rejects alternative work meeting all of the conditions listed in Labor Code §4644(a)(6). Attach RU-94.
- ☐ 7. The employer offers and the employee accepts a job not meeting criteria of #5 or #6. *(Attach RU-94)*

NOTICE TO EMPLOYEE

If you agree with the above, no further action is required on your part, and we will not be providing vocational rehabilitation services in the future.

If you disagree with our determination that we have no further liability to provide vocational rehabilitation services, you or your representative must submit your written objections and the reasons for them to the Rehabilitation Unit within twenty (20) days of receipt of this Notice. The form to use to make your objection is enclosed. Be sure to send a copy to me. The Rehabilitation Unit will then determine if you are to be given further services. Please send a copy of this Notice, with your objection, to the Rehabilitation Unit located at: *(insert Rehabilitation Unit address)*

If you have any questions about this notice, you may contact me at: _____.

(Voc. Rehab.) §10133.16

Mandatory Format
State of California
DWC Form RU-105 (01/03)

Notice of Termination of Vocational Rehabilitation Benefits (DWC Form RU-105) Back – Dates of Injury On or After 1/1/90

SUMMARY OF SERVICES PROVIDED			
Number of weeks of VRMA: (Within the cap) \$ _____ Total Amount of paid VRMA: (Within the cap) \$ _____ Total Amount of PD supplement: \$ _____ Amount Paid for QRR: \$ _____	RU-94 Offer <input type="checkbox"/> Modified Job (L.C. 4644 (a)(5)) <input type="checkbox"/> Alternate Job (L.C. 4644 (a)(6)) <input type="checkbox"/> "Other Job" (L.C. 4644 (a)(7)) Did employee RTW? Yes _____ No _____ If Yes, employee's new job title: _____ Wages: \$ _____ per _____ (Hour/Week/Month)		
DOIs on/after 1/1/94 VR initiated before 1/1/98 VR initiated on/after 1/1/94 Phase I: \$ _____ Phase A: \$ _____ Phase II: \$ _____ Phase B: \$ _____ Phase III: \$ _____ Total Cost of QRR Services: \$ _____ QRR Name: _____ Total Cost of Other VR Services: \$ _____ Amt. Withheld for Employee's Attorney (if any) \$ _____		Plan Completion Plan Type <input type="checkbox"/> Direct Placement <input type="checkbox"/> OJT <input type="checkbox"/> Training <input type="checkbox"/> Self Employment <input type="checkbox"/> Modified Job <input type="checkbox"/> Alternate Job Employed in Plan Objective: Yes _____ No _____ If Yes, employee's new job title: _____ Wages: \$ _____ per _____ (Hour/Week/Month)	

PROOF OF SERVICE BY MAIL

I am a citizen of the United States and a resident of the County of: _____. I am over the age of eighteen years and not a party to the within matter. My business address is: _____.

On _____, I served the Notice of Termination of Vocational Rehabilitation Services on the parties listed below by placing a true copy thereof enclosed in a sealed envelope with postage fully prepaid, and thereafter deposited in the U.S. Mail at the place so addressed.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed at _____ on _____ 20_____.

Signature

Copies Served On:

(Voc. Rehab.) §10133.16

Mandatory Format
State of California
DWC Form RU-105 (01/03)

Disputes in Vocational Rehabilitation

- An Informal Conference must be sought before requesting a Rehabilitation Unit (Formal Conference).
- Rehabilitation Unit (Formal) Conference
 - If parties are unable to resolve disputed rehabilitation issues, any party may file a *Request for Dispute Resolution* form (RU-103).
 - The Rehabilitation Unit Consultant will schedule a conference to try to resolve the issues.
 - If parties are unable to resolve issues, the consultant will issue a determination.
 - Either party may appeal determination to the Workers' Compensation Appeals Board.
 - Rehabilitation Unit Consultant will base their determination on:
 - The California Labor Code
 - The Administrative Rules/Regulations
 - Administrative Guidelines
 - The Standards Governing Timeliness and Quality of VR Services

Request for Dispute Resolution (DWC Form RU-103)

Request for Dispute Resolution ___ Original ___ Response		Has employer accepted this claim? ___ Yes ___ No Has liability for injury been found by the WCAB? ___ Yes ___ No Has more than 90 days of TTD been paid? ___ Yes ___ No		Rehabilitation Use Only	
Social Security Number		WCAB Number		Rehab Unit Number	
Employee Name (Last)		(First)		(MI) Date of Birth	
Address (Street)		(City)		(State) (Zip)	
Employer Name			Insurance Company Name; Or, if Self-Insured, Certificate Name		
Address			Adjusting Agency Name (if adjusted)		
City, State, Zip			Claims Mailing Address		
Date of Injury		Claim Number		City, State, Zip Phone No.	
Employee Representative			Employer Representative		
Firm Name			Firm Name		
Address			Address		
City, State, Zip		Phone No.		City, State, Zip Phone No.	
Qualified Rehabilitation Representative Firm Name Representative Name					
Address (Street, City, State, Zip) Phone No.					
The Rehabilitation Unit is requested to resolve the following dispute on an expedited basis because the parties disagree on : (Check the single issue which applies) ___ The identification of a vocational goal (for injuries after 1/1/94) ___ The description of the employee's job duties at the time of injury (for injuries after 1/1/94) ___ The selection of a Independent Vocational Evaluator ___ The employee objects to the attached Notice of Intent to Withhold Maintenance Allowance					
Non-Expedited Issues: (Check the issue(s) that apply) ___ The employee objects to a Notice of Termination ___ The employee's medical eligibility for vocational rehabilitation services. Medical report relied upon by requester: _____ ___ The employer has failed to provide vocational rehabilitation services and benefits. My QRR preference is: (if any) _____ On what date should the employer have provided vocational rehabilitation services? ___ / ___ / ___ (Attach explanation) Date last worked ___ / ___ / ___ Date of last temporary disability ___ / ___ / ___ ___ The employee requested reinstatement and the employer failed to respond. On what date was request made to claims administrator? ___ / ___ / ___ How does the employee substantiate this request? [Attach supporting document(s)] ___ This is in response to a previously submitted RU-103 dated ___ / ___ / ___ ___ Other disputed issues (please describe the nature): _____					
Summary of Parties' Informal Efforts to Resolve this Dispute An informal conference was held on _____. A summary of the conference, including a list of attendees, issues addressed, agreements reached and other unresolved issues is attached. If an informal conference was not held, attach explanation.			Copies of this request with copies of medical and vocational reports have been served on:		
Name of Requester		Date		Signature	

(Voc. Rehab.) §10133.14

Mandatory Format
 State of California
 DWC Form RU-103 (01/03)

Settlement of Prospective Vocational Rehabilitation Services

- LC 4646 (b)
- (a) Settlement or commutation of prospective vocational rehabilitation services shall not be permitted under Chapter 2(commencing with Section 5000) or Chapter 3 (commencing with Section 5100) of Part 3 except as set forth in subdivision (b), or upon a finding by a workers' compensation judge that there are good faith issues that, if resolved against the employee, would defeat the employee's right to all compensation under this division.
- (b) The employer and a represented employee may agree to settle the employee's right to prospective vocational rehabilitation services with a one-time payment to the employee not to exceed ten thousand dollars (\$10,000) for the employee's use in self-directed vocational rehabilitation. The settlement agreement shall be submitted to, and approved by, the administrative director's vocational rehabilitation unit upon a finding that the employee has knowingly and voluntarily agreed to relinquish his or her rehabilitation rights. The rehabilitation unit may only disapprove the settlement agreement upon a finding that receipt of rehabilitation services is necessary to return the employee to suitable gainful employment.
- (c) Prior to entering into any settlement agreement pursuant to this section, the attorney for a represented employee shall fully disclose and explain to the employee the nature and quality of the rights and privileges being waived.

Settlement of Prospective Vocational Rehabilitation Service (DWC Form RU-122) – page 1 of 3

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SETTLEMENT OF PROSPECTIVE VOCATIONAL REHABILITATION SERVICES [LC § 4646 (b)]			REHABILITATION USE ONLY				
Social Security No:		Claim Number:		WCAB Case No. (if any):		RU Case No. (if any):	
Employee Name (Last) (First) (MI)				Date of Birth			
Address (Street) (City) (State) (Zip Code)							
Date of Injury				If Self Insured, Certificate Name or Insurer Name			
Employer Name				Adjusting Agency Name (if adjusted)			
Employer Address				Claims Mailing Address			
City, State, Zip Code				City, State, Zip Code			
Employee's Attorney				Employer's Representative			
Firm Name				Firm Name			
Address				Address			
City, State, Zip Code Phone No.				City, State, Zip Code Phone No.			
Qualified Rehabilitation Representative (if any)							
Firm Name							
Address							
City, State, Zip Code Phone No.							
<p>In accordance with Labor Code 4646:</p> <p>1. The parties to this agreement are the employee _____ and the employer or claims administrator _____.</p> <p>2. All parties agree that any vocational rehabilitation benefits paid and accrued prior to the date this agreement has been signed are separate and distinct funds from the amount settled in this agreement.</p>							

MANDATORY FORMAT

STATE OF CALIFORNIA

DWC FORM RU-122 01/03

Settlement of Prospective Vocational Rehabilitation Service (DWC Form RU-122) – page 2 of 3

Page 2 of 3

3. The parties hereby agree to settle the employee's right to prospective Vocational Rehabilitation services with a one-time payment to the employee for the sum of \$ _____, less the sum of \$ _____, as reasonable attorney's fee. The requested attorney's fee will be held in trust by the employer subject to approval and subsequent order by the Workers' Compensation Appeals Board.

4. The employee's attorney has fully disclosed and explained to the employee the nature and quality of the rights and privileges being waived and settled by the parties. The employee has knowingly and voluntarily agreed to relinquish his or her rehabilitation rights.

Employee's signature _____ Date _____

Employee's Attorney's signature _____ Date _____

Qualified Interpreter's signature _____ Date _____
(if needed)

5. The employee understands and agrees that the settlement is to be applied to his/her self-directed vocational rehabilitation, such as direct placement, training, self-employment.

Signatures

Employee _____ Date _____

Employee's Attorney _____ Date _____

Employer's Representative _____ Date _____

Determination of the Rehabilitation Unit

The Rehabilitation Unit has reviewed this Settlement Agreement pursuant to Labor Code § 4646 (b) and (c). The Rehabilitation Unit, hereby, **approves** this Settlement Agreement.

Rehabilitation Unit Consultant _____ Date _____

OR

The Rehabilitation Unit has reviewed the Settlement Agreement pursuant to Labor Code § 4646 (b) and it is, hereby, **disapproved**. Reason for Disapproval: _____

Rehabilitation Unit Consultant _____ Date _____

The Rehabilitation Unit shall approve or disapprove the settlement agreement of vocational rehabilitation. If disapproval is not made within ten (10) days of receipt of a fully executed agreement, the agreement shall be deemed approved.

This Agreement is Final. Any aggrieved party must file an appeal with the Workers' Compensation Appeals Board within twenty (20) days from the date this Agreement is approved, deemed approved or disapproved.

Settlement of Prospective Vocational Rehabilitation Service (DWC Form RU-122) – page 3 of 3

Page 3 of 3

If Vocational Rehabilitation Services were commenced:

Summary of Services Provided

Number of weeks of VRMA: _____

Total Amount VRMA Paid: \$ _____

Total Amount of PD Supplement: \$ _____

Amount Paid QRR for:

DOI's on or after 1/1/03

Phase A: \$ _____

Phase B: \$ _____

Total costs of QRR services \$ _____

QRR Name _____

Total other costs of rehabilitation services: \$ _____

Amount withheld for Employee's Representative, if any: \$ _____

If plan developed, plan type: _____

Completed by: _____ Date: _____

Roles and Responsibilities

Department of Personnel Administration Responsibilities

The Department of Personnel Administration's (DPA) Workers' Compensation and Safety Program (WCSP) is responsible for managing the States Workers' Compensation Program.

The role and responsibilities of the DPA shall include but are not limited to:

- The Department of Personnel Administration (DPA) shall work with State Fund and the departments to ensure that employees are returned to work in the most expeditious manner.
- DPA, in conjunction with State Fund, will provide training to the Return to Work Coordinators (RTWC) on finding alternative positions for injured workers.
- DPA shall provide guidelines to the departments on assisting injured workers' return to work.
- DPA shall monitor departments and State Fund for compliance with applicable laws, regulations, executive orders, and policies and procedures.
- DPA, with the assistance and cooperation of State Fund vocational rehabilitation staff, will develop training materials for vocational rehabilitation counselors on returning state employee back to State service. The training material will be developed within 6 months of the inception of this agreement.

State Fund's Responsibilities

State Fund utilizes in-house Vocational Rehabilitation Coordinators (VRC) to oversee the provision of vocational rehabilitation benefits to injured workers. Once the injured worker has been determined to be medically eligible, has been offered vocational rehabilitation services, and has requested services, the VRC, in conjunction with the employee, or the injured worker's attorney, if represented, decide on an Agreed Qualified Rehabilitation Representative (QRR).

The QRR agreement will be confirmed in writing and will give details as to what services will be provided. The VRC continues to oversee the provision of vocational rehabilitation benefits, including plan authorization and dispute resolution. The VRC is available to assist the QRR with efforts to return State employees to State service.

The role and responsibilities of State Fund shall include but are not limited to:

- State Fund shall be responsible for ensuring the provision of vocational rehabilitation benefits when an injured worker is entitled to those benefits. State Fund shall provide these benefits in accordance with the Labor Code and the
- Regulations set forth by the Division of Workers' Compensation.
- State Fund shall find out from the department whether a modified or alternative position is available. If a position is not available and the employee is, or is presumed to be, a qualified injured worker (QIW), State Fund will refer the employee for vocational rehabilitation services.
- The State Fund VRC will give written notice to the department when an employee becomes, or is presumed to be, a QIW and will provide the medical limitations to the RTWC to facilitate the search for an alternative position.
- The State Fund VRC will consult with the RTWC during the development phase of a plan and prior to agreeing to a plan. State Fund will give first consideration to a viable vocational rehabilitation plan that returns the injured worker to State service.
- Copies of all Rehabilitation Unit (RU) Forms, vendor reports, and Decisions and Orders from the Rehabilitation Unit will be sent to the RTWC by the State Fund VRC at the department's request.
- State Fund's VRC will make the determination that a proposed plan should be approved, if the department does not have an alternative job available for the employee. State Fund will give first priority to viable vocational rehabilitation plans that provide the injured worker with the skills needed to return to State service.
- State Fund will attempt to utilize a QRR who (1) has experience and/or has been trained on the process for obtaining and maintaining a job in State service, and (2) has a working knowledge of the Americans with Disabilities Act, the Fair Employment and Housing Act, and the process of reasonable accommodation.
- State fund shall notify the RTWC when paying expenses outside the vocational rehabilitation cap or when authorizing retroactive benefits.

Employer Responsibilities

Each State department is required to designate a Return-to-Work Coordinator (RTWC), Departmental Claims Coordinator (DCC), or departmental designee who is responsible for facilitating the early return to work of the department's injured employees. This individual is also responsible for monitoring the administration of a department's workers' compensation claims and case management. In the event an employee becomes disabled and cannot perform the duties of his or her usual and customary position, it is typically the RTWC's role to help the injured worker with identifying any viable employment available in the department.

The role and responsibilities of the employer departments shall include but are not limited to:

- Comply with the applicable Sections of the Government Code, Labor Code, California Code of Regulations, and Executive Order D-48-85 regarding returning employees to work and actively seek employment opportunities for employees who become disabled.
- Identify the RTWC or departmental designee who is responsible for assisting the injured worker in returning to work.
- Identify the classification(s) for which the injured worker qualifies and that fit within provided work restrictions.
- Provide the injured worker with information regarding the Injured State Workers' Assistance Program (ISWAP). If the injured worker would like to participate in ISWAP, submit an application for the ISWAP listing up to six classifications.
- Conduct a job search of all vacant departmental positions fitting both the injured worker qualifications and work restrictions.
- Notify the QRR if a position is located and send a job analysis or description to the QRR for submission to the primary treating physician for review and comment prior to placing the injured worker in the position.
- Work cooperatively with the QRR in locating a position within the originating department.
- The RTWC or departmental designee shall provide information to State Fund that could impact plan selection or development within 10 calendar days of receiving State Fund's notice that the injured worker has accepted vocational rehabilitation. This information should include but is not limited to the availability of modified or alternate work, requested job descriptions, or other information required by the Division of Workers' Compensation.

- The RTWC or departmental designee shall express in writing (e-mail, FAX or letter) any concerns about the proposed goal within 15 calendar days of receiving notice of the plan.
- The RTWC or departmental designee shall cooperate with the State Fund VRC and the QRR when the need arises for a job analysis or related purposes.
- The RTWC or departmental designee shall be available upon request to attend Division of Workers' Compensation Rehabilitation Unit proceedings (e.g., formal conferences, trials).

Qualified Rehabilitation Representative Responsibilities

State Fund requires that each Qualified Rehabilitation Representative (QRR) have on file with the Risk Management Department of State Compensation Insurance Fund a current certificate (or memorandum) of insurance showing professional liability of at least \$1 million per occurrence and \$3 million in aggregate.

The role and responsibilities of the agreed-upon QRR shall include but are not limited to:

- Clarify and identify the injured worker's medical work restrictions (mental or physical) as contained in the medical record.
- Identify limitations that may affect successful return to suitable gainful employment.
- Clarify with the employer the work restrictions provided by the State Fund VRC to facilitate a departmental search of available vacant positions for which the injured worker qualifies and which fit within documented work restrictions.
- Identify/clarify with the RTWC the job classifications for which the injured worker is qualified to reinstate or transfer to and which fit within the injured worker's work restrictions.
- Prior to placing the injured worker in a vacant position, send the job analysis or description to the primary treating physician for review and approval.
- Provide a list of the potential job classifications to the employer to assist in the inter-departmental search.
- Provide the injured worker with information regarding the ISWAP. If the injured worker would like to participate in ISWAP, notify the RTWC to initiate the process.

- Help the injured worker develop a resume and complete the California State Government Examination/Employment Application (Std. 678).
- Assist the injured worker in a job search utilizing all available resources.
- If the injured worker is required to interview for a position outside the original department, counsel him or her on interviewing skills.
- If a position is located in the original department, notify the employer designee and State Fund VRC immediately.

Injured Employee Responsibilities

The roles and responsibilities of the State employee should include but are not limited to:

- Work cooperatively with both the QRR and the employer to identify, locate, and obtain suitable gainful employment.
- Provide any medical documentation outlining current or permanent work restrictions.
- Fully participate in developing and completing a vocational rehabilitation plan.

Supplemental Job Displacement Benefit (SJDB)

SJDB replaces vocational rehabilitation benefits for eligible injured employees injured on or after January 1, 2004. There is no qualified injured worker threshold requirement as in vocational rehabilitation benefits. In addition, an injured employee does not receive VRMA.

To be eligible for SJDB, the injured employee must meet the following criteria:

- Has to have permanent partial disability; and
- Hasn't returned to work for his or her date of injury employer within 60 days of TD ending.

The employer is not liable for the SJDB if the employer offers a modified or alternative job within 30 days of TD ending, meeting the following criteria:

- Paying at least 85% of the salary at the date of injury;
- Lasting at least 12 months;
- Within a reasonable distance; and
- The injured employee can perform the essential functions of the job.

The SJDB is a voucher for a educational retraining or skill enhancement program at a state approved or accredited school. The voucher can range in value up to \$10,000 based on the level of an injured employee's permanent disability and can be used towards tuition, fees, books, up to 10% for vocational rehabilitation counselor services, and other related expenses. The table below states shows the voucher amount based on the injured employees level of disability:

Voucher Amount	Permanent Partial Disability
Up to \$4000	1 to 14%
Up to \$6000	15 to 25%
Up to \$8000	26 to 49%
Up to \$10000	50 to 99%

It is important that the employer continue to work with SCIF to return the injured employee back to modified or alternative work if available. An employer needs to continually check the availability of modified or alternative work that meets the aforementioned criteria. If such work is available, the employer needs to contact SCIF immediately.